City of Scottsdale COBRA/Retiree Benefits Optional Open Enrollment Form

MARK CHANGES ONLY!

Effective Date: July 1, 2004

If you are keeping the same benefits, do not complete this form, your current benefits will continue through June 30, 2005.

FOR HUMAN RESOURCES USE ONLY ____ Complete ____ Keyed on _____	Received on:

Last Name	First Name, MI	Social Security Number

MEDICAL

- ☐ **AETNA OPEN ACCESS EPO** (408)
- ☐ **MMSI HEALTH TRADITION PPO** (410)
- ☐ **AETNA OPEN CHOICE PPO** (418)
- ☐ NO MEDICAL

Is this a change? ☐ Yes ☐ No

LEVEL of COVERAGE

- ☐ Enrollee

AND

- ☐ Spouse
- ☐ Domestic Partner*
- ☐ Child(ren)
- ☐ Domestic Partner's Child(ren)*

DENTAL

- ☐ **ASSURANT DENTAL (Formerly Fortis Dental) (HMO)** (425)
  Dental Office ID# _____**
- ☐ **CITY OF SCOTTSDALE SCOTTSMILES PPO DENTAL** (420)
- ☐ NO DENTAL

Is this a change? ☐ Yes ☐ No

LEVEL OF COVERAGE

- ☐ Enrollee

AND

- ☐ Spouse
- ☐ Child(ren)

ALTERNATIVE MEDICINE

- ☐ ALTERNATIVE HEALTHCARE OPTIONS (431)
- ☐ NO ALTERNATIVE MEDICINE

Is this a change? ☐ Yes ☐ No

LEVEL OF COVERAGE

- ☐ Enrollee

AND

- ☐ Spouse
- ☐ Child(ren)

ENHANCED VISION

- ☐ EYEMED VISION CARE (432)
- ☐ NO ENHANCED VISION

Is this a change? ☐ Yes ☐ No

LEVEL OF COVERAGE

- ☐ Enrollee

AND

- ☐ Spouse
- ☐ Child(ren)

***DOMESTIC PARTNERSHIP COVERAGE**

Only Retirees can cover domestic partners, and only on medical coverage. In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an enrollee to enroll a domestic partner for insurance coverage, both the enrollee and the domestic partner must complete the Domestic Partnership Affidavit. City of Scottsdale Human Resources must approve the affidavit prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. Enrollees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage.

****DENTAL OFFICE ID#**

The dental office you choose will be applicable for you and your dependents unless you specify a different dental office for your dependents in the dependent section.

QUALIFIED LIFE STATUS CHANGES

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change such as the birth of a child, marriage or divorce. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any claims incurred by an ineligible dependent.

TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE

Benefits Optional Open Enrollment Form (continued)

DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED IN ANY NEW PLAN)

Dependent children between ages 19 and 25 must be enrolled in at least six credit hours to be eligible for coverage.

Spouse Name (Last, First MI)	Date of Birth	Gender

Spouse is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Domestic Partner's Name* (Last, First MI)	Date of Birth	Gender

Domestic Partner is covered on the following plan(s):
☐ Medical

Dependent 1 Name (Last, First MI)	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 1 is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Dependent 2 Name (Last, First MI)	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 2 is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Dependent 3 Name (Last, First MI)	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 3 is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Dependent 4 Name (Last, First MI)	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender

Dependent 4 is covered on the following plan(s):
☐ Medical ☐ Dental – If Assurant, Dental Office # (if different from employee): _____ ☐ Alternative Medicine ☐ Enhanced Vision

Additional dependents may be listed on a separate page.

AUTHORIZATION: By execution of this enrollment form, I understand that I may not change the election during the coming year except in the event of a life change. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are eligible for coverage under the plan.

Signature _____ Date _____